

§ 417.830

(1) Explains CMS's determination of total reimbursement due the HCPP for the reporting period; and

(2) Informs the HCPP of its right to have the determination reviewed at a hearing in accordance with the requirements specified in § 405.1801(b)(2) of this chapter.

(d) *Payment of amounts due.* (1) Within 30 days of CMS's determination, CMS or the HCPP, as appropriate, will make payment of any difference between the total amount due and the total interim payments made to the HCPP by CMS.

(2) If the HCPP does not pay CMS within 30 days of CMS's determination of any amounts the HCPP owes CMS, CMS may offset further payments to the HCPP to recover, or to aid in the recovery of, any overpayment identified in its determination.

(3) Any offset of payments CMS makes under paragraph (d)(2) of this section will remain in effect even if the HCPP has requested a hearing in accordance with the requirements specified in § 405.1801(b)(2) of this chapter.

(e) *Tentative settlement.* (1) If a final settlement cannot be made within 90 days after the HCPP submits the report specified in paragraph (b) of this section, CMS will make an interim settlement by estimating the amount payable to the HCPP.

(2) CMS or the HCPP will make payment within 30 days of CMS's determination under the tentative settlement of any estimated amounts due.

(3) The tentative settlement is subject to adjustment at the time of a final settlement.

[50 FR 1375, Jan. 10, 1985, as amended at 58 FR 38081, July 15, 1993; 73 FR 30267, May 23, 2008]

§ 417.830 Scope of regulations on beneficiary appeals.

Sections 417.832 through 417.840 establish procedures for the presentation and resolution of organization determinations, reconsiderations, hearings, Departmental Appeals Board review, court reviews, and finality of decisions that are applicable to Medicare enrollees of an HCPP.

[59 FR 59943, Nov. 21, 1994, as amended at 61 FR 32348, June 24, 1996]

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§ 417.832 Applicability of requirements and procedures.

(a) The administrative review rights and procedures specified in §§ 417.834 through 417.840 pertain to disputes involving an organization determination, as defined in § 417.838, with which the enrollee is dissatisfied.

(b) Physicians and other individuals who furnish items or services under arrangements with an HCPP have no right of administrative review under §§ 417.834 through 417.840.

(c) The provisions of part 405 dealing with the representation of parties apply to organization determinations and appeals.

(d) The provisions of part 405 dealing with administrative law judge hearings, Medicare Appeals Council review, and judicial review are applicable, unless otherwise provided.

[59 FR 59943, Nov. 21, 1994, as amended at 70 FR 4713, Jan. 28, 2005]

§ 417.834 Responsibility for establishing administrative review procedures.

The HCPP is responsible for establishing and maintaining the administrative review procedures that are specified in §§ 417.830 through 417.840.

[59 FR 59943, Nov. 21, 1994]

§ 417.836 Written description of administrative review procedures.

Each HCPP is responsible for ensuring that all Medicare enrollees are informed in writing of the administrative review procedures that are available to them.

[59 FR 59943, Nov. 21, 1994]

§ 417.838 Organization determinations.

(a) *Actions that are organization determinations.* For purposes of §§ 417.830 through 417.840, an organization determination is a refusal to furnish or arrange for services, or reimburse the party for services provided to the beneficiary, on the grounds that the services are not covered by Medicare.

(b) *Actions that are not organization determinations.* The following are not organization determinations for purposes of §§ 417.830 through 417.840:

(1) A determination regarding services that were furnished by the HCPP,

either directly or under arrangement, for which the enrollee has no further obligation for payment.

(2) A determination regarding services that are not covered under the HCPP's agreement with CMS.

[59 FR 59943, Nov. 21, 1994]

§417.840 Administrative review procedures.

The HCPP must apply §422.568 through §422.626 of this chapter to—

(a) Organization determinations and fast-track appeals that affect its Medicare enrollees; and

(b) Reconsiderations, hearings, Medicare Appeals Council review, and judicial review of the organization determinations and fast-track appeals specified in paragraph (a) of this section.

[75 FR 19803, Apr. 15, 2010]

Subpart V—Administration of Outstanding Loans and Loan Guarantees

§417.910 Applicability.

The regulations in this subpart apply, as appropriate, to public and private entities that have loans or loan guarantees that—

(a) Were awarded to them before October 1986 under section 1304 or section 1305 of the PHS Act; and

(b) Are still outstanding.

[59 FR 49842, Sept. 30, 1994]

§417.911 Definitions.

As used in this subpart—

Any 12-month period means the 12-month period beginning on the first day of any month.

Expansion of services means—(1) The addition of any health service not previously provided by or through the HMO, that requires an increase in the facilities, equipment, or health professionals of the HMO; or

(2) The improvement or upgrading of existing facilities or equipment, or an increase in the number of categories of health professionals, of the HMO so that the HMO could provide directly services that it previously provided through contract or referral or which it could not previously provide with its existing facilities or equipment.

First 60 months of operation or expansion means the 60-month period beginning on the first day of the month during which the HMO first provided services to enrollees, or in the case of significant expansion, first provided services in accordance with its expansion plan.

Health system agency means an entity that has been designated in accordance with section 1515 of the PHS Act; and the term *State health planning and development agency* means an agency that has been designated in accordance with section 1521 of the PHS Act.

Initial costs of operation means any cost incurred in the first 60 months of an operation or expansion that met any of the following requirements:

(1) Under generally accepted accounting principles or under accounting practices prescribed or permitted by State regulatory authority, was not a capital cost.

(2) Was required by State regulatory authority to meet reserves or tangible net equity requirements.

(3) Was for a payment made to reduce balance sheet liabilities existing at the beginning of the 60-month period, but only if—(i) The payment had been approved in writing by the Secretary; and

(ii) The total of these payments did not exceed 20 percent of the amount of the loan.

(4) Was for a small capital expenditure, but only if—(i) The cost had been approved in writing by the Secretary; and

(ii) The total of these costs did not exceed \$200,000 in any 12-month period, and \$400,000 during the first 60 months of operation or expansion.

Nonprofit as applied to a private entity, means a private agency, institution, or organization, no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual.

Significant expansion means—(1) A planned substantial increase in the enrollment of the HMO, that requires an increase in the number of health professionals serving enrollees of the HMO or an expansion of the physical capacity of the HMO's total health facilities; or

(2) A planned expansion of the service area beyond the current service area,